Connecticut Health Insurance Exchange

June 2012

[SHOP BRIEFING]

An overview of the Small Business Health Options Program (SHOP) Exchange

Overview

The federal health care reform law directs states to set up health insurance marketplaces, called "Health Benefit Exchanges," that will enable individuals, families and employers to purchase health insurance from a range of commercial insurers offering a variety of health plans. Starting in 2014, the Exchange will serve as a central point of access for health insurance, providing eligible individuals, families and small employers with the ability to select from a number of "qualified health plans."

Lower- and middle-income individuals and families with income up to four times the Federal Poverty Level (FPL) – which for a family of four is $92,200 in calendar year 2012 – may be eligible for subsidized health insurance (i.e., advance premium tax credits and reduced out-of-pocket costs) through the American Health Benefit Exchange. Small employers will be able to purchase health coverage through the Small Business Health Options Program or "SHOP" Exchange.

In 2014 and 2015, firms with 50 or fewer full-time workers will be eligible to purchase coverage through the SHOP Exchange.[1] In January 2016, the state is required to expand the small group market and employers with up to 100 workers will be able to buy insurance through the SHOP Exchange. And in 2017, the Exchange may choose, but is not required, to allow large employers (i.e., businesses with over 100 full-time employees) to purchase coverage through the SHOP Exchange.

SHOP Employee Eligibility Limits	
2014	*50 or fewer*
2015	*50 or fewer*
2016	*up to 100*
2017	*>100*

Small employers with less than 25 workers may be eligible for tax credits for the employer's share of the premium for up to two years if they purchase coverage through the Exchange. The tax credit, which is based both on the size of the employer's workforce and the average wages paid to employees, may be as much as 35% of the employer's share of the premium for tax exempt employers and 50% of the employer's share of the premium for taxable employers.[2]

Employers with 10 or fewer employees may be eligible for the full credit (i.e., 50% of the employer's share of the premium), while employers with 11 – 24 workers may be eligible for a tax credit that covers a lower percentage of the premiums depending on the total number of workers.

[1] Prior to 2016, the state may elect to expand the small group market to employers with up to 100 employees.
[2] The tax credit is also limited to the lesser of the employer's actual premium or the statewide average premium for employer-sponsored insurance.

The tax credit is also affected by the average wages paid to employees. Employers with average wages of $25,000 or less may be eligible for the full tax credit, which is reduced as the average wages increase. No credits are available to employers with average wages of $50,000 or more.

Employees that are offered coverage through the SHOP Exchange are not eligible for the advance premium tax credits and reduced cost-sharing that will be available through the individual Exchange.

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The Basics

Many of the requirements of the SHOP Exchange are identical or similar to those of the individual market Exchange; including, but not limited to, the essential health benefits that must be covered, the types of information provided to consumers/employees, the rating of health plans based on quality and price, and the health plan reporting requirements.

Both the SHOP and individual Exchange may only offer "qualified health plans" that provide coverage at specific benefit levels: Platinum, Gold, Silver, and Bronze. Benefit levels are based on "actuarial value," which is a summary measure of the amount of medical claims paid by the health plan (excluding a member's point-of-service cost sharing), expressed as a percentage of the total medical claims incurred for a standard population.

Plan Levels
covering % of cost of care

Platinum	*90%*
Gold	*80%*
Silver	*70%*
Bronze	*60%*

Platinum plans will cover 90 percent of the cost of care, which means an individual purchasing a Platinum plan can expect to have 90 percent of his/her medical costs paid by the health plan, with the remaining ten percent paid through member cost sharing (i.e., co-payments, co-insurance, deductibles). Gold plans will cover 80 percent; Silver plans will cover 70 percent; and Bronze plans will cover 60 percent.

The individual market Exchange may also offer a "catastrophic" or high deductible health plan to certain individuals (i.e., individuals under age 30 or people who are exempt from the individual mandate based on the lack of affordable coverage). These catastrophic plans will not be offered to employers and their employees purchasing insurance through the SHOP Exchange.

The law also limits the maximum annual deductible for health plans purchased by small employers. In 2014, small group health plans may not have an annual deductible that exceeds $2,000 for single coverage or $4,000 for family coverage. These limits do not apply to the individual market, although the actuarial value standards noted above will place limits on the size of the deductible for individual market coverage.

Essential Health Benefits

All plans sold in the individual and small group markets in 2014 and beyond must cover all of the "essential health benefits" (EHB). The health reform law outlines a basic definition of essential health benefits and directs the Secretary of Health and Human Services (HHS) to further define the EHB package. On December 16, 2011, HHS released a bulletin that previewed the proposed approach for defining the EHB, in which HHS directs the states to define the EHB for plan years 2014 and 2015. Under this approach, each state will select a "benchmark plan" from among ten possible options:

- The three largest plans in the state's small group market;
- The three largest state employee health benefit plans;
- The three largest federal employee health benefit plans; and,
- The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) in the state.

Rating Rules

The law also requires that health plans in both the individual and small group markets comply with a common set of rules, including:

- Guaranteed issue and guaranteed renewal (i.e., an applicant cannot be denied coverage and cannot be dropped at the time of renewal);
- No use of health status as a rating factor (i.e., a person or group cannot be charged a higher premium based on his/her health status or a pre-existing condition);
- A limited set of factors that may be used to set premiums (e.g., age, geographic location, family composition); and,
- Rates may not vary by more than 3:1 based on the applicant's or group's age (e.g., the premium charged older applicants or groups may be no more than three times the premium charged younger applicants or groups).

While health plans sold in the individual and SHOP Exchange will have common rating requirements; unless the risk pools are combined, the premiums for coverage will likely differ between the individual and small group markets. That is, premiums for a health plan offered in the individual market may have different premiums than the same health plan sold in the small group market.

Purchasing Options

The manner by which employers and employees purchase coverage through the SHOP Exchange will be one of the most important policy decisions, and may be a key factor in the success of the SHOP Exchange. Policy decisions include participation requirements, contribution requirements, and the employer and employee purchasing models. Each is discussed briefly below.

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Participation Requirements

Currently, health carriers that offer coverage in the small group market generally require a minimum percentage of employees to enroll in coverage as a pre-condition for offering group coverage. Groups with two to 50 employees are typically required to enroll 75% of their employees in the group's health plan, unless an employee is otherwise covered as a spouse or as a dependent. If an employer cannot meet this threshold, the insurer will not sell the policy to the group.

Contribution Requirements

Carriers also require employers to contribute a minimum amount of the monthly premium – generally 50 percent of the premium for single coverage – as a pre-condition for insuring a group. Employers unable or unwilling to contribute at least 50 percent of the premium are generally not offered group insurance by the carrier.

The participation and contribution requirements protect against adverse selection and the risk of bad debt. Adverse selection describes a situation in which an individual's demand for insurance, and level of coverage, is directly related to the individual's perceived need for insurance. Older and sicker individuals may be more likely to participate in the insurance plan or enroll in the most comprehensive coverage; while younger and healthier individuals may choose to go without coverage or opt for a more limited health plan.

A key policy decision for Connecticut will be whether the participation and contribution requirements that apply to employers purchasing coverage outside of the Exchange should apply to employers that purchase coverage through the Exchange.

Because the carriers may not know the health status of the group's members, they are unable to adjust prices to account for this selection bias. By requiring all employees or a majority of employees to be covered by the group policy, the carriers can minimize the potential for adverse selection. The contribution requirement helps reduce the risk of bad debt.

A key policy decision for Connecticut will be whether the participation and contribution requirements that apply to employers purchasing coverage outside of the Exchange should apply to employers that purchase coverage through the Exchange.

Four Purchasing Models

1) *One Carrier, One Plan*
2) *One Carrier, Multiple Plans*
3) *All Carriers, One Plan Level*
4) *All Carriers, All Plans*

Employer and Employee Purchasing Models

The manner by which employers and employees purchase coverage through the SHOP Exchange will impact the extent to which the Exchange can effectively serve the group market. While there may be any number of purchasing models that one could develop, listed below are four options. These models are not necessarily mutually exclusive, in that Connecticut may choose to allow employers to select a purchasing option.

One Carrier, One Plan

This model reflects the traditional way that employers, particularly small employers, purchase health insurance. The employer selects a carrier and a health plan, and the employees are allowed to enroll in the plan. The SHOP Exchange could be used by the employer to compare health plans, assess premium contribution options, and select a carrier and health plan to offer to employees

SHOP Exchange Purchasing Model

One Carrier, One Plan

Monthly Premiums for Single Coverage (Example)

Health Plan/Carrier	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	$540	$531	$518	$554
Gold	$480	$472	$460	$492
Silver	$420	**$413**	$403	$431
Bronze	$360	$354	$345	$369

A composite rate could be developed for the group (i.e., monthly premiums for single coverage, employee plus one, family coverage), and the employer's and employees' share of the premiums would be set for the entire group.

One Carrier, Multiple Plans

Under this purchasing model, the employer would select a health carrier and allow employees to enroll in any of the health plans offered by that carrier through the SHOP Exchange. The table below illustrates how this might be structured. A slight modification to this model might restrict employees' choices to a sub-set of the health plans offered by a carrier.

SHOP Exchange Purchasing Model

One Carrier, Multiple Plans

Monthly Premiums for Single Coverage (Example)

Health Plan/Carrier	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	$540	**$531**	$518	$554
Gold	$480	**$472**	$460	$492
Silver	$420	**$413**	$403	$431
Bronze	$360	**$354**	$345	$369

Under this example, the employer "selects" Carrier B and employees may choose from any of the health plans offered by that insurer. The employer could set its share of the premium as a percentage of the cost of a specific plan (e.g., 70% of the cost of Carrier B's Silver plan), as a percentage of all plans' premiums, or as a specific dollar amount.[3] In the example below, if the employee selects the Silver plan, the employee pays 30% of the cost.

The employee would have the option of taking the employer's contribution – in this example, $289 – and purchase a Gold or Platinum Plan, which would cost the employee more, or a Bronze Plan, which has a lower employee contribution. The employer's share of the cost is fixed, while the employee's amount will vary depending on which plan the employee selects. The table below shows how this might work for an individual employee.

[3] Under certain purchasing models, premiums could vary based on the age of the employee. Pursuant to the Age Discrimination in Employment Act (ADEA), an employer is not allowed to provide a defined contribution or flat dollar amount per employee if doing so results in older employees paying a larger percentage of a health plan's premium than the share paid by younger employees.

SHOP Exchange Purchasing Model

One Carrier, Multiple Plans

Premium Contributions for Single Coverage (Example)

Carrier B	Total Monthly Premium	Employer's Share of the Premium	Employee's Share of the Premium
Platinum	$531	$289	$242
Gold	$472	$289	$183
Silver	$413	$289	$124
Bronze	$354	$289	$65

Because employees could select from a number of health plans offered by a carrier, it is likely that the group's premiums would need to switch from composite rating to list bill rating. Under composite rating, premiums are set on a group basis, and the same rates apply to all employees that enroll in coverage for a given rate basis type (i.e., individual, employee plus one, family policy). The group's premiums are essentially determined by the average age of the group's members. Under list bill rating, premiums are set for each employee that enrolls in coverage. Premiums are determined on an individual basis and vary based, primarily, on the age of the employee and his or her family members.

All Carriers, One Plan Level

Under this purchasing model, the employer selects a plan level (i.e., Platinum, Gold, Silver, or Bronze) and employees can select from any of the health carriers within a given plan level. The table below illustrates how this might be structured.

SHOP Exchange Purchasing Model

All Carriers, One Plan Level

Monthly Premiums for Single Coverage (Example)

Health Plan/Carrier	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	$540	$531	$518	$554
Gold	$480	$472	$460	$492
Silver	**$420**	**$413**	**$403**	**$431**
Bronze	$360	$354	$345	$369

The employer "selects" the Silver Level plan and employees may choose from any of the health carriers that offer a Silver Level plan through the SHOP Exchange. The employer could set its premium contribution as a percentage of the cost of a specific plan (e.g., 70% of the cost of Carrier B's Silver plan). If the employee selects Carrier B's Silver plan, the employee pays 30% of the cost.

The employee would also have the option of taking the employer's contribution – in this example, $289 – and purchasing a Silver Plan from any of the other carriers. The employer's share of the cost is fixed, while the employee's share varies depending on which carrier the employee selects. The table below shows how this might work for an individual employee.

SHOP Exchange Purchasing Model

All Carriers, One Plan Level

Premium Contributions for Single Coverage (Example)

Carriers' Silver Level Plan	Total Monthly Premium	Employer's Share of the Premium	Employee's Share of the Premium
Carrier A	$420	$289	$131
Carrier B	$413	$289	$124
Carrier C	$403	$289	$113
Carrier D	$413	$289	$141

Because employees may select from a number of health carriers within a plan level, premiums would likely be set on an individual (i.e., list bill) basis, as discussed above.

All Carriers, All Plans

Under this purchasing model, employees would be allowed to select from any of the health plans offered by the health carriers participating in the Exchange. The employer's share of the premium could vary based on the percentage of the premium (e.g., 70% of any plan's premium), could be set based on the premium of a particular plan offered by a specific carrier (e.g., 70% of the Silver Level Plan offered by Carrier B), or the employer could provide employees with a specific dollar amount and allow them to apply the employer's contribution to any health plan offered through the SHOP Exchange.

SHOP Exchange Purchasing Model

All Carriers, All Plans

Monthly Premiums for Single Coverage (Example)

Health Plan/Carrier	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	$540	$531	$518	$554
Gold	$480	$472	$460	$492
Silver	$420	$413	$403	$431
Bronze	$360	$354	$345	$369

As with the previous two purchasing models, because employees may select from any of the health carriers, premiums would likely need to be set on a list bill basis.

Each of these models brings with it implications for the Exchange's attractiveness and sustainability, operational and administrative challenges, the potential for adverse selection, and ramifications for the broader commercial insurance market. Connecticut will need to evaluate the advantages and disadvantages of each purchasing option, and determine which model or models may work best for the state's employers, employees and insurers.

Premium Billing, Collection and Remittance

The need for the Exchange to efficiently administer premium billing, collection, and remittance will be particularly crucial. Depending on how the SHOP Exchange structures its purchasing model, employees may be able to choose coverage from a number of health carriers. If the health plans are responsible for premium billing and collection, an employer purchasing coverage through the SHOP Exchange would need to pay multiple health carriers for, and need to establish contractual relationships with, each of the carriers selected by the employees.

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From an employer's perspective, the prospect of paying multiple insurers will greatly diminish the attractiveness and value of purchasing coverage through the Exchange. In addition to receiving multiple invoices and issuing multiple checks for employees' health coverage, by not centralizing the premium billing and other administrative functions within the Exchange, the employer would need to deal with various carriers to handle mid-year changes in employment, changes in status for existing employees, and all of the other administrative tasks that are now handled through one health carrier or through a broker.

In light of those administrative challenges, the Exchange is the most appropriate entity to assume responsibility for premium billing, collection, and remittance to the carriers, as well as other administrative responsibilities, such as mid-year changes in enrollment, COBRA notification, etc.

These and many other issues will need to be addressed as Connecticut establishes a SHOP Exchange, develops the administrative processes and procedures to offer insurance to employers, and works with health carriers to structure a small group market that works for all entities.